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Supreme Court, U.S.
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IN THE

Supreme Court of the United States

THE BLACK & DECKER DISABILITY PLAN,

Petitioner,

—v.—

KENNETH L. NORD,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF DELTA FAMILY-CARE DISABILITY AND SURVIVORSHIP PLAN AND DELTA AIR LINES, INC. AMICI CURIAE IN SUPPORT OF PETITIONER THE BLACK & DECKER DISABILITY PLAN

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QUESTION PRESENTED

Whether the United States Court of Appeals for the Ninth Circuit erred in holding that the treating-physician rule must be applied in deciding claims for disability benefits under the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

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INTEREST OF THE AMICI CURIAE[1]

The Delta Family-Care Disability and Survivorship Plan (the "Plan") is a non-contributory employee welfare benefit plan, established and maintained pursuant to the

[1] Petitioner and Respondent have consented to the filing of this Brief. No counsel for a party authored this Brief in whole or in part. No persons or entities other than the *Amici Curiae* made a monetary contribution to the preparation or submission of this Brief.

Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001 *et seq.*[2] It is sponsored by Delta Air Lines, Inc. ("Delta"). The Plan provides short-term disability, long-term disability and survivorship benefits to over 80,000 non-pilot employees of Delta and their beneficiaries. The Plan has participants in almost every state and is currently subject to a split in the Circuits on the Question Presented. *Compare Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130, 1139 (9th Cir. 2001) (2 to 1 decision) (applying treating-physician rule to ERISA disability cases) *with Turner v. Delta Family-Care Disability and Survivorship Plan*, 291 F.3d 1270, 1274 (11th Cir. 2002) (*per curiam*) (rejecting *Regula* and the treating-physician rule in ERISA disability cases) *and Marshall v. Delta Family-Care Disability and Survivorship Plan*, 258 F.3d 834, 842 (8th Cir. 2001) (same). The Plan is also the Petitioner in *Delta Family-Care Disability and Survivorship Plan v. Regula*, No. 01-1840 (June 13, 2002), which presents the same Question Presented as well as a second question.

STATEMENT OF THE CASE OF THE AMICI CURIAE

This Court has granted certiorari to the United States Court of Appeals for the Ninth Circuit to review that Court's decision in *Nord v. Black & Decker Disability Plan*, 296 F.3d 823 (9th Cir. 2002). In that case, a panel of the Ninth Circuit, in an opinion written by Judge Betty Fletcher, followed its prior decision in *Regula v. Delta Family-Care Disability and Survivorship Plan*, 266 F.3d 1130 (9th Cir. 2001), also written by Judge

[2] The text of the brief will only cite to sections of ERISA as codified in the United States Code. Parallel citations to sections of ERISA are found in the Table of Authorities. *See supra* at v.

Fletcher, and applied the so-called "treating-physician rule" to a case involving an ERISA claim for long-term disability benefits under the Black & Decker Disability Plan.

Because the Court in *Nord* merely applied the treating-physician rule that it had created in *Regula*, *Nord*, 296 F.3d at 829, much of the analysis and reasoning behind its creation of that new ERISA rule is found in the *Regula* decision. The analysis in *Regula*, in turn, reflects various assumptions regarding the Plan that the Ninth Circuit majority made without any record evidence. Before explaining why the treating-physician rule should be inapplicable to ERISA disability cases and should be rejected by this Court, a description of the Plan's actual operation with respect to claims such as Frank Regula's, as opposed to the Ninth Circuit's unfounded assumptions, is necessary. This description reflects the experiences of the Plan's agents regarding the Plan's operation during the time period that Frank Regula's benefits were discontinued and he completed the exhaustion of administrative remedies (*i.e.*, the Plan Year ending June 30, 1996). The description is stated in general terms because there may be specific claims with respect to which the Plan acted differently based upon the unique facts of that particular claim.

1. The Plan provides short-term, long-term and survivorship benefits to participating non-pilot Delta employees. To receive short-term disability benefits, a participant must generally be unable to perform their own job at Delta. With exceptions not relevant here, short-term disability benefits last for a maximum of 26 weeks. After short-term disability benefits are exhausted, a participant may apply for long-term disability benefits. The standard for long-term disability is more rigorous. It requires a participant to be unable to perform any part-

time or full-time work of any type for any employer, including self-employment. This standard is markedly different than the Social Security Administration standard for the payment of disability benefits. *See infra* at 17-18.

2. The Plan is administered by the Administrative Committee of Delta Air Lines, Inc. ("Administrative Committee"). The Administrative Committee is the Plan's Named Fiduciary and is vested with the discretion to decide claims under the Plan. *See Regula*, 266 F.3d at 1144. The Administrative Committee is composed of Delta employees as authorized by ERISA. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 105 (1989).

The Administrative Committee is more familiar with terms and application of the Plan than any entity outside the Plan or any Court. In the year relevant to Regula's appeal to the Administrative Committee for the continuation of his benefits, the Administrative Committee heard 51 appeals regarding the denial or discontinuation of disability benefits under the Plan. Over 25 percent of the appealed decisions were reversed in favor of the Claimant.[3] This figure does not include other appeals decided in favor of claimants by the Administrative Subcommittee which provides the first level of review under the Plan.[4]

The Plan is funded by irrevocable contributions that Delta makes to a qualified trust based upon expected claims. The assets of the trust far exceeded the claims

[3] For comparison's sake, this is far greater than the 9.5% reversal rate of the federal Courts of Appeals. *See*, Administrative Office of the United States Courts, U.S. Courts of Appeals—Appeals Terminated on the Merits During the 12-Month Period Ending March 31, 2002. *www.uscourts.gov/caseload2002/tables/605mar02.pdf*.

[4] Only those appeals denied by the Administrative Subcommittee may be appealed to the Administrative Committee.

made under the Plan in the Plan year relevant to Regula's claim. In the Plan year ending June 30, 1996, the trust's assets were $350,315,163.00 against claims of $28,935,736.00. Thus, Delta had essentially pre-paid all of the claims made against the Plan (and then some) in those years with funds that could not revert to Delta. Delta did this even though neither ERISA, nor any other law, requires Delta to provide this funding through irrevocable contributions or otherwise. *See, e.g.*, 29 U.S.C. §§ 1081-86 (limiting ERISA's funding requirement to certain defined pension benefit plans).

After a claimant[5] is approved for the receipt of long-term disability benefits, the Plan provides that those benefits are continued upon its periodic receipt of additional, current information regarding the claimant's condition. At the time Regula's benefits were discontinued, this information was usually required to be provided every three to twelve months. *See, e.g., Regula*, 266 F.3d at 1134 (noting that Regula was required to submit updated information every three months).

Once a claimant begins to receive long-term disability benefits, there are generally only two occurrences that lead to a thorough re-examination of eligibility for disability benefits. The first is a report to the Plan from a third party that the claimant is actually working while receiving benefits or engaging in activities inconsistent with the claimed disability. As a result, despite the medical evidence submitted by the claimant's physician, these claimants may well be ineligible for benefits under the Plan depending upon the result of the Plan's subsequent investigation. The second circumstance that normally precedes a re-examination of a claimant's eligibility

[5] The term "claimant" as opposed to "participant" is used to distinguish a participant who has filed a claim from the other participants in the Plan.

is the claimant's own physician's indication that the claimant can perform some work or that claimant's condition is improving to a substantial degree.

In the first case, when there has been a report that a claimant is actually working or engaging in activities inconsistent with the claimed disability, the Plan will usually first ask the claimant's own physician for an update on claimant's condition and also schedule an examination with an independent medical expert. In the second case, where the claimant's own physician indicates that claimant is improving or may be able to return to work, depending on the Plan's evaluation of the information, the claimant's benefits may be immediately discontinued or the claimant may be sent to an independent evaluation for additional examination. The latter often occurs when the claimant's physician only opines that the claimant is unable to perform his own job as opposed to any occupation.

3. The Plan does not have as employees its own physicians for the purpose of performing medical examinations. Typically, the Administrative Committee uses a third-party service that provides references to physicians who have attained certain qualifications in the relevant specialty. On occasion, the Plan itself may directly select a physician if the Plan is aware that the physician is an expert in the relevant field and is otherwise suitable to examine the claimant. Ironically, of those independent medical examiners selected by the Plan, some are physicians who have treated other claimants and whose reports and analysis were seen as thorough, reasoned and well-founded by the Plan's agents, regardless of whether the physician thought that the claimant was disabled. Of those *qualified* physicians from whom the Plan received an opinion, the thoroughness of the opinion is the primary factor that leads the Plan to seek additional opinions from that physician in other claims.

The Ninth Circuit's decision in *Regula* begins its analysis from the simple misguided assumption: Claimant's physician good, independent physician bad. *See Regula*, 266 F.3d at 1139 & 1143. Given the Plan's processes, as described above, the Ninth Circuit's assumption was surprising and unsupported. The Ninth Circuit analysis also starts from another false, unsupported assumption—that Delta repeatedly sends its claimants to the same independent physicians because they routinely find claimants not disabled. *Id.* at 1144. Not only was this argument not advanced by Regula, but there is no record evidence for it and the Ninth Circuit provided no citation to the record or otherwise to validate this assumption.

It is true that, as in the *Regula* case, when there are orthopaedic injuries involved the Plan usually finds it more relevant to seek the opinion of an orthopaedist rather than some other type of medical professional such as a chiropractor, though the Plan accepts and analyzes each opinion on its own merits. This reasonable preference is also ignored by the Ninth Circuit's analysis. All told, there is no factual basis for the Ninth Circuit's assumptions that the Plan's independent medical examiners are biased, less capable or repeatedly used by the Plan because the Plan believes they will find a claimant able to work.

Finally, the Plan's experience shows that using a preference in favor of the treating physician's opinion would result in a situation where the Administrative Committee could not fulfill its fiduciary duty. It is not unusual that an employee claiming an inability to work, seeks to return to work immediately after disability benefits are discontinued. Since a physician's clearance is generally required to return to work, that claimant's physician often has a sudden

change of opinion and releases the claimant to work. Given this knowledge, the Plan Administrator could be forced to disregard its fiduciary duty if mandated to defer to the treating physician's view.[6]

SUMMARY OF ARGUMENT

The treating-physician rule is contrary to this Court's decision in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989) and ERISA. It conflicts with *Firestone's* holding that decisions of a fiduciary vested with discretion will not be disturbed if they are reasonable. *Id.* at 111. It fails to recognize the fiduciary relationship of a Plan Administrator and needlessly interferes with fiduciary administration of the Plan by dictating the weight of certain evidence. As applied, the rule effectively gives the claimant's physician the right to control receipt of benefits, as opposed to the Plan Administrator. This strips the ERISA claims fiduciary of its discretion and transfers that discretion to the claimant's physician. The *fiduciary obligation and responsibility*, however, remain with the now powerless fiduciary, while the claimant's physician, who is devoid of *any* fiduciary obligation to the Plan and the other participants, wields the Plan's purse strings. For the reasons outlined below, this rule is unnecessary given the safeguards of ERISA, and its application serves to stand ERISA's framework and this Court's decision in *Firestone* on their respective heads.

The Ninth Circuit attempted to justify its decision by stating that the rule increases the consistency between

[6] Additionally, the Plan has seen claimants return to work in order to qualify for special benefits that accompany various voluntary resignation programs. These claimants too, had physicians who consistently opined the claimant could not work until the special program became available.

ERISA disability decisions and Social Security Act, 42 U.S.C. §§ 401-33, disability decisions. This ignores the fact that Congress lets ERISA Plan sponsors set the standard for disability in an ERISA Plan, but fixed a specific standard for disability under Social Security. Not only has Congress expressed no intent that these decisions should be "consistent", but it has established vastly different decision-making processes for each which reflects an expectation of divergent results. The entire structure of the Social Security Act was aimed at providing a detailed regulatory complex that left administrative law judges with only a narrow range of discretion to decide individual cases. The regulatory addition of the treating physician rule to the Social Security disability regulations, therefore, did not significantly affect the discretion of Social Security Act administrative law judges to decide claims under the Social Security Act. On the contrary, the ERISA Plan Administrator is subject to a discrete set of claims regulations promulgated by the Department of Labor which leaves the Plan Administrator's broad discretion intact.

Thus, the application of this rule affects a significant reduction in the discretion accorded to Plan Administrators under ERISA. The Ninth Circuit's desire to treat the two the same lacks any basis in logic, not to mention law.

LEGAL ARGUMENT

I. THE TREATING PHYSICIAN RULE CANNOT BE RECONCILED WITH THIS COURT'S DECISION IN *FIRESTONE*

Before examining the treating physician rule's compatibility with ERISA, it is important first to understand the rule's effect. Following this Court's decision in

Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101 (1989), the federal courts of appeals reached a consensus as to the standard of review applicable to cases in which the Plan administrator was vested with sufficient discretion to invoke the arbitrary or capricious standard of review. Virtually all of the courts of appeals have held that the substantial evidence test, which requires that the evidence supporting a decision be less than a preponderance of evidence, but more than a scintilla, applies when the applicable standard is arbitrary or capricious. *See, e.g., Terry v. Bayer Corp.*, 145 F.3d 28, 41 (1st Cir. 1998); *Pagan v. NYNEX Corp.*, 52 F.3d 438, 442 (2nd Cir. 1995); *Abnathya v. Hoffmann-La Roche, Inc.*, 2 F.3d 40, 45 (3d Cir. 1993); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999); *Salley v. EI DuPont de Nemours & Co.*, 966 F.2d 1011, 1016 (5th Cir. 1992); *Miller v. Metropolitan Life Ins. Co.*, 925 F.2d 979, 984 (6th Cir. 1991); *Gallo v. Amoco Corp.*, 102 F.3d 918, 921 (7th Cir. 1996); *Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 841-43 (8th Cir 2001); *McKenzie v. General Tel. Co. of Ca.*, 41 F.3d 1310, 1316 (9th Cir. 1994); *Woolsey v. Marion Labs., Inc.*, 934 F.2d 1452, 1460 (10th Cir. 1991); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 (11th Cir. 1997).

The Ninth Circuit's decisions in *Nord* and *Regula* supplanted this *Firestone* standard by adopting the treating-physician rule. As crafted by the Ninth Circuit, that rule requires that when the treating physician and the independent physician are in conflict, the Plan administrator and/or the reviewing court *must* presume that the treating physician is correct and the independent physician is wrong unless there is substantial evidence, accompanied by "specific, legitimate" reasons for crediting the independent physician more than the treating physician. *See Regula*, 266 F.3d at 1140. Thus, while there might be

more than substantial evidence in the record as a whole to support the Plan's decision, all of that evidence would be irrelevant if between the treating physician and the independent physician the evidence was at equipoise. *Id.*

The consequence of violating the treating physician rule, as demonstrated in *Regula*, is the application of a *de novo* standard of review. *Id.* at 1145 ("If the Plan fails to carry its burden [of showing that any alleged conflict did not affect the Plan's decision] then we review *de novo* its decision denying benefits.") This is directly contrary to *Firestone* which holds that a conflict never results in *de novo* review, though it may reduce the deference afforded to the administrator. *Firestone*, 489 U.S. at 115. The rule further violates *Firestone* by conflating various steps in the process of reviewing a benefits claim decision. After *Firestone*, a court should first inquire as to whether the Plan's terms vest discretion in the Plan Administrator. *Id.* at 115. If such discretion was vested in the Plan Administrator, then the Court would move on to see whether or not there was a conflict of interest which would affect the degree of deference afforded to the Plan Administrator. *Id.* Finally, depending on which standard of review would apply, the benefit decision would be reviewed either for reasonableness under the abuse of discretion standard, or *de novo* because the Plan did not vest discretion in the administrator. *See id.* The Ninth Circuit's decision applies the treating physician rule to the middle step in the analysis, such that if the treating physicians opinion is not followed, there is little, if any, chance that the fiduciary is not operating under a conflict of interest. The Ninth Circuit's decision to create this rule for ERISA was one of judicial fiat and is not based on any precedent or logic. As demonstrated below, it is virtually impossible to avoid *de novo* review because even objectively supportable and *reasonable* factors were not accepted by the Ninth Circuit in *Regula*.

In practice, the rule is demonstrably draconian. In *Regula*, the Plan stated that the independent medical psychiatrist's opinion that Regula was malingering was based on two factors: (1) the overall examination; and (2) Regula's refusal to consider prescription drug treatment. This finding was unrebutted by the "treating" psychologist. *See id.* at 1135 (describing conflicting opinions but not noting that claimant's physician disagreed with or considered the finding of malingering). Further, the "treating" psychologist (1) indicated an improper bias in favor of Regula by assailing the report of an orthopedist and, therefore opining outside her area of expertise in the process, *id.* at 1135; and (2) proffered inconsistent opinions, *id.* at 1153 (Brunetti, J., dissenting). Moreover, the Plan preferred the opinion of the orthopedist to that of a chiropractor because it gave more credence to the opinions of medical doctors as opposed to osteopaths. (Appendix to Petition in 01-1840 at 109a (no current opinion from an M.D.)). Yet, even this was not enough for the Ninth Circuit majority as it held that not even these reasons were "specific, legitimate" reasons based on substantial evidence in the record. *Regula*, 266 F.3d at 1146-47. Given the virtually insurmountable level of evidence required by this Ninth Circuit rule as shown in its application, it is totally inconsistent with this Court's ruling in *Firestone*.

II. THE TREATING PHYSICIAN RULE CANNOT BE RECONCILED WITH ERISA GENERALLY

The Ninth Circuit's rule is also inapplicable given ERISA's structure. To the extent the rule is outcome determinative, it regulates the substantive content of an employee welfare benefit plan contrary to ERISA. *See Intermodal-Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Railway Co.*, 520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts.*,

471 U.S. 724, 732 (1985)). To the extent it portends to merely affect the claims regulation process, it is inconsistent with the claims regulations issued by the Department of Labor for ERISA benefit claims. *See* 29 U.S.C. § 2560.503-1. As a result, there is no interstice for the Ninth Circuit to create federal common law in this instance.

The rule is also inconsistent with the structure of ERISA when one focuses on the fiduciary duties assigned to those who administer the Plan. Decisions under ERISA plans are made by fiduciaries. *See Firestone*, 489 U.S. at 105. These fiduciaries are subject to ERISA's high standards that require them to act only in the best interest of Plan participants and beneficiaries. 29 U.S.C. § 1104(a)(1). ERISA prohibits fiduciaries from acting in the best interest of the Plan sponsor/employer. *See* 29 U.S.C. § 1106(b). ERISA likewise prohibits self-dealing and dealings with parties in interest. *See Harris Trust & Savings Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238, 242 (2000). Failing to comply with these rules subjects ERISA fiduciaries to *personal* liability. 29 U.S.C. § 1109(a).

Concomitant with this high level of responsibility is a broad recognition of the fiduciary discretion to make decisions under the plan when the terms of the plan vest that discretion in the fiduciary (as it is undisputed by Respondent they both did in the Black & Decker and Delta Plans). *See Firestone*, 489 U.S. at 111. When that discretion is committed to the fiduciary, the fiduciary's interpretation will not be disturbed so long as it reasonable. *Id.* As such, this Court has recognized that the fiduciary has obligation first to follow the terms of the Plan. *See Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 83 (1995). This is consistent with ERISA's requirement that each benefit Plan be established and

maintained "pursuant to a written instrument." 29 U.S.C. § 1102(a)(1); *Curtiss-Wright*, 514 U.S. at 83. This requirement enables the participant to examine the Plan documents and determine their rights and obligations under the Plan. *Curtiss-Wright*, 514 U.S. at 83 (quoting H.R. Rep. No. 93-1280, at 297 (1974), 1974 U.S.C.C.A.N. 4639, 5077, 5078).

On the other hand, physicians who provide reports and opinions to benefit plans are subject to none of ERISA's fiduciary obligations. Instead, their obligations flow directly to their patients, and rightly so, *regardless* of the terms of the Plan. *See Pegram v. Herdrich*, 530 U.S. 211, 218 (2000). Indeed, this Court has previously held that even where the physician's decision regarding eligibility for a Plan benefit is mixed with a decision about medical treatment, the decision is not subject to ERISA's fiduciary obligations. *Pegram*, 530 U.S. at 231. Instead, the fiduciary duty still lies with the Plan Administrator which is solely responsible for making decisions about "distributing [benefits] to [participants and] beneficiaries." *Id.* at 231 (citing G. Bogert & G. Bogert, Law of Trusts & Trustees §§ 551, 741-47, 751-75, 781-99 (rev. 2d ed. 1980); 2A, A. Scott & W. Fratcher on Trusts, §§ 176, 181 (4th ed. 1987); 3 *id.*, §§ 188-93; 3A *id.*, § 232).

Against this backdrop of (1) a clear assignment of fiduciary duties and obligations to the Plan Administrator; and (2) a clear statement to Plan participants that they must look to the Plan Administrator as the arbiter of the Plan, the Ninth Circuit's decision improperly shifts the decision-making power to a non-fiduciary. This is contrary to ERISA's fiduciary scheme.

The Ninth Circuit's decision also violates the fundamental structure of ERISA which carefully balances the fiduciary's decision-making power with the heavy burden of fiduciary responsibility and liability. In transferring only the decision-making power, but leaving the fiduciary duty responsibility and obligations on the Plan Administrator, the Ninth Circuit has shattered the Congressional design. The result is that a party with no burden to follow ERISA is empowered to make the decisions that will affect the Plan participants, while the party that has all of the burden to make the correct decision essentially has little or no power to make the correct decision. The problem with this separation is not merely theoretical and has manifested itself in the Ninth Circuit's decisions.

The *Regula* case is a prime example. In that case, the Plan specifically stated that it was not crediting Claimant's treating psychologist because she had opined outside her area of expertise in apparent bias and sympathy for Claimant. Additionally, after first stating that Regula was psychologically ready to return to work subject to his orthopaedic limitations, she suddenly changed her opinion when the orthopaedic limitations were removed. Further, the Plan explained that with respect to the physicians, it credited the position of the orthopaedist over the chiropractor because of a preference for orthopaedists to make orthopaedic decisions. The Ninth Circuit held that this simply was not good enough to defeat the treating physician rule.

The result of the Ninth Circuit's decision in *Regula* was to shift the power to decide whether Regula's benefits would continue to (1) Regula's psychologist opining outside her areas of expertise; and (2) Regula's chiropractor, neither of whom had any *obligation* to actually follow the terms of the Plan. While they have a heavy incentive to opine in favor of their own patient's interests, and arguably an ethical obligation to do so, they owe no duty to any of the other participants or ben-

eficiaries in the Plan who have a right to know that the claims of others will be decided under the terms of the Plan by the Plan Administrator and that the assets of the Plan will not be squandered on the claims of participants who are not qualified for the Plan's benefits in accordance with those terms. Conversely, the Administrative Committee is the one entity that is in a better position to understand exactly how the Plan is evenly applied across *all* participants and beneficiaries. It also has the fiduciary responsibility under ERISA to decide claims. It now, however, has virtually no decision-making authority when the claimant's physician opines favorably to the claimant. Yet, the Plan Administrator still remains responsible to all of the other participants and beneficiaries to see that the Plan is administered and its assets spent in accordance with its terms.

The treating physician rule cannot be applied to an ERISA plan fiduciary, consistent with ERISA's structure. Under this rule, decisions regarding eligibility for benefits will not be made by the ERISA-fiduciary Plan Administrator, but by the physicians of claimants who are currently seeking benefits. These physicians are complete strangers to the Plan with no knowledge of how the Plan's disability standard has been applied previously nor responsibility to apply the terms so that the Plan's assets are preserved only for those participants eligible for the benefits. As a result, the Ninth Circuit's rule clearly contravenes ERISA's fundamental allocation fiduciary responsibility.

III. THE NINTH CIRCUIT IMPROPERLY IMPORTED A SOCIAL SECURITY REGULATION INTO ERISA

ERISA does not regulate the substantive content of employee welfare benefit plans. *Intermodal-Rail Employees Ass'n v. Atchison, Topeka and Santa Fe Railway Co.*,

520 U.S. 510, 515 (1997) (quoting *Metropolitan Life Ins. Co. v. Massachusetts.*, 471 U.S. 724, 732 (1985)). This was one way that Congress addressed the chief concern that in establishing ERISA it did not want "to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place." *Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996). Congress did give the Department of Labor the ability to create regulations regarding *how* ERISA benefit claims are to be decided and the Department has issued 29 C.F.R. § 2560.503-1 as a result. This regulation imposes a mechanism for benefit claimants to administratively appeal adverse benefits decisions. It includes the right of the claimant to submit information in support of the claim and to know the basis for the Plan administrator's decision. *Id.* That claim regulation specifically requires the Plan to consult an independent medical physician when it is not persuaded by the treating physician's opinion. *Id.* § 2560-503-1(h)(3)(iii) & (4). The regulation does not require that any deference be paid to the treating physician's opinion. *See id.*

Congress acted much differently in creating a public welfare benefit system under the Social Security Act. Within the Social Security Act, Congress has established an elaborate, highly-regulated public disability benefit authority. *See, e.g.*, 42 U.S.C. §§ 401-34; 20 C.F.R. § 404.1-.2127, 416.101-2227. Unlike the Delta Plan in *Regula*, the Social Security Act provides benefits even when an individual might be able to perform some work. *Heckler v. Campbell*, 461 U.S. 458, 461-62 (1983) (existence of jobs claimant can perform does not preclude disability finding). Unlike ERISA Plans, which often look at the effect of a given condition on an individual, the Social Security Act grids automatically entitle claimants with certain impairments to receipt of benefits

even if individuals with that impairment may actually be able to work. *See* 20 C.F.R. § 404.1520(d). The Social Security Act also requires a specified analysis of the job qualifications of an individual who does not meet one of these absolute criteria. 42 U.S.C. § 423(d)(2)(A); 20 C.F.R. § 404.1520(f). Much of this structure is necessary because of the sheer volume—in the millions of claims per year—that the Social Security Administration handles. *Heckler*, 461 U.S. at 464 n.2.

Despite the obvious dissimilarity of the Social Security Act and ERISA benefit schemes, the Ninth Circuit held that it was only "common sense" that the results under both should be consistent. This is wrong on at least two levels.

First, as this Court held in *Firestone*, ERISA is not based on the Social Security Act. Rather Congress intended to incorporate much of the Labor Management Relations Act's fiduciary law into ERISA. *See Firestone*, 489 U.S. at 109. Conversely, in drafting ERISA, Congress was only concerned with the Social Security Act in terms of the calculation of pension benefits, not welfare benefits. *See* 29 U.S.C. §§ 1054(b)(1)(B)(iv), 1054(b)(1)(C), 1054(b)(1)(G); *Alessi v. Raybestos-Mahhattan, Inc.*, 451 U.S. 504, 514-15 (1981) (*same*).

Second, given that the eligibility standards for benefits under an ERISA Plan are almost always different than, and usually stricter than, the Social Security standard, as is the case with Delta's Plan, there is no reason why consistency between ERISA and Social Security Act decisions should be expected. The end result of this consistency, of course, would be to reverse every Court of Appeals (including the Ninth Circuit's prior panel opinion in *Madden v. ITT Long-Term Disability Plan For Salaried Employees*, 914 F.2d 1279, 1285 (9th Cir. 1990)) which has held that an ERISA disability plan is not

bound by decisions of the Social Security, or any other, governmental benefit program. *See Delta Family-Care Disability and Survivorship Plan v. Marshall*, 258 F.3d 834, 842 n.11 (8th Cir 2001) (under the same Plan at issue in *Regula*, because of the discretion granted to the ERISA Plan Administrators, the administrator is not bound by governmental disability decisions) need not be followed by the Plan); *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1452 n. 5(11th Cir. 1997) (also concerning the same Plan as at issue in *Regula* and distinguishing the Social Security Act); *Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442-43 (2d Cir. 1995) (differing standards of disability between governmental and private Plans to preclude similar results); *Hale v. Trustees of United Mine Workers' Health & Retirement Funds*, 23 F.3d 899, 902 (4th Cir. 1994) (same). In fact, this result has already occurred in one court of appeals. *See Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 529-30 (6th Cir. 2003) (holding that an ERISA Plan which offsets benefits by Social Security Benefits may be estopped from not following the Social Security disability decision), *petition for rehearing en banc filed* (Feb. 5, 2003).

The reasoning behind the Ninth Circuit's rule supplants ERISA welfare benefit law with the law of the Social Security Act. The error of this position is manifest. Why would Congress have gone to such detail to set up two drastically different schemes if it wanted them to be the same? The answer is that Congress did not mean for them to be the same and it therefore made them drastically different. As a result, the Ninth Circuit's rule has no place.

The Ninth Circuit also thought that ERISA and the Social Security Act were similar because both ERISA Plan Administrators and Administrative Law Judges

under the Social Security Act have discretion in deciding benefit claims. It is wrong to conclude, however, that the narrow discretion under the highly regulated Social Security scheme is the same as the broad discretion of a Plan Administrator under ERISA. By analogy, both an adult and a child exercise discretion in deciding what to eat, but because the adult can drive and likely has greater wealth, the adult's discretion would involving choosing between numerous restaurants within a city. At the same time, the child's discretion would likely be between the types of food readily available in the home. The Ninth Circuit would equate these acts of choice because they both involve "discretion". The Ninth Circuit is just as wrong in justifying importation of the treating-physician rule from Social Security Act by comparing the discretion of an Administrative Law Judge under the Social Security Act and the discretion of a Plan Administrator under ERISA.

CONCLUSION

For the foregoing reasons, this Court should reverse the United States Court of Appeals for the Ninth Circuit's decision in *Nord v. Black & Decker Disability Plan*, hold that the treating-physician rule does not apply as a matter of law pursuant to ERISA and order the Ninth Circuit to enter judgment in favor of The Black & Decker Disability Plan.

This 24th day of February, 2003.

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